

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07978					07952				
Item #8 & 9 Film #9389 6/15/67									
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG RD#1			c. LENGTH OF STAY IN 1b 50 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG RD#1			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #140					d. STREET ADDRESS Route #140				
3. NAME OF DECEASED (Type or print) First JOHN Middle PRESTON Last ALBAUGH			4. DATE OF DEATH Month JUNE Day 7 Year 1967						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 JULY 25, 1887		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) CARROLL Co. MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN THOMAS ALBAUGH					14. MOTHER'S MAIDEN NAME MILLIE ABERILLA HANN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -			16. SOCIAL SECURITY NO. 220-09-6095A		17. INFORMANT MISS H. MADELINE ALBAUGH			Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension					INTERVAL BETWEEN ONSET AND DEATH 15 minutes				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/10, 1949 , to 6/7, 1967 , that (I) (we) last saw the deceased alive on 6/1, 1967 , and that death occurred at 3:41 PM , from the causes and on the date stated above.									
22a. SIGNATURE Julius Chepko					22b. DATE SIGNED 6/7/67				
22c. PHYSICIAN'S NAME (Type) Julius Chepko MD					22d. ADDRESS 858 W. Green St Westminster MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 6/10/67		23c. NAME OF CEMETERY OR CREMATORY BETHEL (CARROLLTON) CEM			23d. LOCATION (City, town or county) (State) FINKSBURG RD#1 MD.	
24. FUNERAL DIRECTOR J. S. Smyth, Jr. WESTMINSTER, MD 21157					25a. REC'D BY REGISTRAR J. Charles Judge				
25b. REGISTRAR'S SIGNATURE J. Charles Judge					25c. DATE JUN 12 1967				

07979

CERTIFICATE OF DEATH

07963

1. PLACE OF DEATH a. COUNTY <i>Springfield State Hospital</i>		USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto. City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>1yr. 2 mo. 7 da.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Springfield State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George Mooter</i>		4. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>1967</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7-26-85</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>----</i>	9. AGE (In years last birthday) <i>81</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>KENTUCKY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Mooter Ball</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Springfield Record</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral atherosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronici Brain Syndrome assoc. with senile brain disease without qualifying phrase</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5-16</i> , 19 <i>66</i> , to <i>6-9</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-8</i> , 19 <i>67</i> , and that death occurred at <i>3</i> P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>Mario E. Comas</i>		22b. DATE SIGNED <i>6-9-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>MARIO E. COMAS</i>		22d. ADDRESS <i>1302 KENSEL CT. BALTO MD.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>6-14-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Cincinnati Ohio</i>
24. FUNERAL DIRECTOR <i>Samy W. Haight</i>		25a. RECEIVED BY REGISTRAR <i>Sykesville, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		DATE <i>JUN 15 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1937

CERTIFICATE OF DEATH

1937

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

07980

CERTIFICATE OF DEATH

07964

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 104 N. Summit Avenue			
3. NAME OF DECEASED (Type or print) First David Middle Edward Last Biddinger				4. DATE OF DEATH Month 6 - Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1894	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bradley Biddinger				14. MOTHER'S MAIDEN NAME Virginia Eaves			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-38-8851		17. INFORMANT Address Springfield Hospital Records, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retro-peritoneal hemorrhage DUE TO (b) Perforated abdominal aorta aneurysm DUE TO (c) 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to June 15, 1967 , that (X) (we) last saw the deceased alive on June 15, 1967 , and that death occurred at 2:20 PM , from causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-15-67	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-19-67	23c. NAME OF CEMETERY OR CREMATORY Union Chapel		23d. LOCATION (City or Town) (County) (State) Frederick Co. Maryland			
24. FUNERAL DIRECTOR Ernest C. Gartner				ADDRESS 224		25a. REC'D BY REGISTRAR JUN 19 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

07981

CERTIFICATE OF DEATH

07965

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mths-15 d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Faharney Kneedy Home	
3. NAME OF DECEASED (Type or print) Ethel Irene Bingham		4. DATE OF DEATH Month June Day 17 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-88
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress		10b. KIND OF BUSINESS OR INDUSTRY Postal	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David H. Bingham		14. MOTHER'S MAIDEN NAME Merryman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-48-0308	
17. INFORMANT Records Address Springfield State Hospital Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal Bronchial Pneumonia (c) Infected Decubitus Ulcers			INTERVAL BETWEEN DEATH AND DEATH Days Days Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-2- , 19 67 , to 6-17- , 19 67 , that (I) (we) last saw the deceased alive on 6-17- , 19 67 , and that death occurred at 10:05am , from causes and on the date stated above.			
22a. SIGNATURE <i>Naci Buyukunsal</i>		22b. DATE SIGNED June 17, 1967	
22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/20/67	23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	23d. LOCATION (City or Town) (County) (State) Knoxville Maryland
24. FUNERAL DIRECTOR Fete Funeral Home		25. REC'D BY REGISTRAR DATE JUN 20 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07982						07986					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
CARROLL			MIDDLEBURG			MARYLAND			KEYMAR		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
11 DAYS			BROOKFIELD MANOR NURSING HOME			KEYMAR			RURAL		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
RUSSELL ELLIS BOHN						JUNE 25 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JULY 1-1900		66 yrs.		Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
FARMER				OWN FARM				USA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
GRANT BOHN						ROSA KOONS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
NO				214-32-4119 THEO BOHN				KEYMAR MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										2 days	
491X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
Cerebral atherosclerosis + thrombosis ③ left hemiparesis										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 1961, to 6/25/67, 1967, that (I) (we) last saw the deceased alive on 6/25/67, 1967, and that death occurred at 4:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
J. H. Caricofe						<input checked="" type="checkbox"/>				6/25/67	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
J H CARICOFE						UNION BRIDGE		MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL				6/28/67		MT UNION		UNION BRIDGE RURAL MD			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
D D Hartzler						Union Bridge, Md		DATE JUN 28 1967		Charles Judge	

07382

CHITRAKUT OF DEATH

07382

100-2-201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07983

07967

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 06-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mineral Hill Road, Box 234				d. STREET ADDRESS Mineral Hill Road, Box 234		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSSELL B. BRASHEAR				4. DATE OF DEATH Month June Day 2 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1893		9. AGE (In years lost birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Brashear				14. MOTHER'S MAIDEN NAME Annie Siemon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-5550		17. INFORMANT Mrs. Elsie Brashear - Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 6/3/67		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-67		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.	
24. FUNERAL DIRECTOR Harry W. Haight				25a. REC'D BY REGISTRAR JUN 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

07984

CERTIFICATE OF DEATH

07968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2 mo. 8 d.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Rt #3, Clopper Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>MAE</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/84</u>	9. AGE in years (last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN - Seckford</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Springfield Hospital Records, Sykesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO (b) <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS 2300, with senile brain disease with psychotic reaction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3-26-67, 1967</u> , to <u>6-3-1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6-3-1967</u> , and that death occurred at <u>1639A</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>NACIN BUYUKUNSAI, M.D.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>NACIN BUYUKUNSAI, M.D.</u>	
22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md. 21784</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rileyville</u>		23d. LOCATION (City or Town) (County) (State) <u>Rileyville, Va.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1351 Rockville</u>				25a. REC'D BY REGISTRAR <u>Pike</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Rockville, Md.</u>				DATE <u>JUN 8 1967</u>			

02884

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL CENTER FOR VITAL STATISTICS

Blank certificate form with horizontal lines for text entry.

DATE OF BIRTH
PLACE OF BIRTH
CITY
STATE
COUNTRY

DATE OF DEATH	PLACE OF DEATH	CITY	STATE	COUNTRY

07985

CERTIFICATE OF DEATH

07969

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R 1</u>	
3. NAME OF DECEASED (Type or print) <u>PAULINE MAUDE CONAWAY</u>		4. DATE OF DEATH <u>JUNE 27 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 28 - 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINE OPERATOR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN H DILLER</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE HALE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-16-0945</u>	
17. INFORMANT <u>ALVA CONAWAY</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Juvenile, arterial system</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1967</u> , to <u>June 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1967</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>6/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>7 Archer St Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>	23d. LOCATION (City or Town) (County) (State) <u>JEFFERSON MD</u>
24. FUNERAL DIRECTOR <u>DD Hartzler & Sons Union Bridge</u>		25a. REC'D BY REGISTRAR <u>June 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08750

STATE OF TEXAS

08750

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07986					07970						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Carroll</u>					b. STATE <u>Maryland</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>						
c. LENGTH OF STAY IN 1b <u>25 YRS.</u>					d. STREET ADDRESS <u>208 PENNIA. AVE.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>208 PENNIA. AVE.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<u>WILLIAM</u>		<u>EDWARD</u>		<u>FARVER</u>		<u>JUNE 16 1967</u>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<u>MALE</u>		<u>WHITE</u>		<u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<u>JUNE 18, 1882</u>		<u>84</u> yrs.		Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>TURN KEY, PRISON</u>				<u> </u>				<u>CARROLL CO. MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
<u>JACOB FARVER</u>					<u>ELIZA JANE YOUNG</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
<u> </u>					<u>216-01-9979</u>		<u>MRS. Emma B. Runhome</u>			<u>Same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>										<u>Several years</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis general</u>										<u>Several years</u>	
(c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<u> </u>		<u> </u>		<u> </u>		<u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>64</u> , to <u>6/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> , 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William Spencer</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/17/67</u>
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
<u> </u>					<u> </u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>Burial</u>			<u>6/19/67</u>		<u>ST. JAMES CEMETERY</u>			<u>NEW WINDSOR RD MD.</u>			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>J. S. Myers Jr.</u>					<u>Westminster, Md.</u>		<u>JUN 20 1967</u>		<u>Charles Judge</u>		

03286

County

Westminster

22 Yrs.

308 FENN AVE.

308 FENN AVE.

WILLIAM EDWARD FARVER

JUNE 12

MALE WHITE

✓

JUNE 18, 1882 34

TURN KEY, PRISON

GARROW CO RD.

JACOB FARVER

ELIZA JANE YOUNG

214-41-444 Mrs James B. Farver

James B. Farver 214-41-444 Westminster, Md.
George 214-41-444 St James Cemetery Westminster, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07987						07971					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>George Viner Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md 21157</u> d. STREET ADDRESS <u>118 Willis</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Ellicott George</u>				4. DATE OF DEATH Month Day Year <u>June 30 1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHOLESALE MEAT PACKING CO. (OWNER)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co, Md</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSIAS GEORGE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>216-03-7759</u>		17. INFORMANT <u>Edith George</u> Address <u>118 Willis Westminster, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> OUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hydronephrosis left kidney</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)		20j. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>6/24</u> , 1967, to <u>6/30</u> , 1967, that (1) (we) last saw the deceased alive on <u>6/26</u> , 1967, and that death occurred at <u>5P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W H Howard</u>						22b. DATE SIGNED <u>6/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. FORD M.D</u>		22d. ADDRESS <u>MANCHESTER, MD 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>7/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baldwin Baltimore Co. Md.</u>		23e. REC'D BY REGISTRAR <u>J. S. Myers</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers</u>				24b. ADDRESS <u>Westminster, Md</u>		24c. DATE <u>JUL 5 1967</u>		24d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		24e. ADDRESS <u>21157</u>	

100-100000

RECEIVED BY THE DIRECTOR

OFFICE OF DEATH

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

24-25-72



1/3/72 At National Library of Medicine
2/2/72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07988

CERTIFICATE OF DEATH

07972

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster 06-1			
c. LENGTH OF STAY IN 1b 1 year				d. STREET ADDRESS 198 David Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 198 David Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Olga Middle Jane Last Gosnell		4. DATE OF DEATH Month June Day 2 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reuben Conaway				14. MOTHER'S MAIDEN NAME Emma Penn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-50-2434		17. INFORMANT Howard H. Gosnell		18. ADDRESS 198 David Ave. Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident, Suspected 332X DUE TO (b) Cerebral Vascular Thrombosis, suspected DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH acute unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. , 1967, to June , 1967, that (I) (we) last saw the deceased alive on June 1 , 1967, and that death occurred at 4 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Philip W. Mercer				22b. DATE SIGNED June 2, 1967		22c. PHYSICIAN'S NAME (Type) Philip W. Mercer	
22d. ADDRESS Westminster, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Sams Creek Cemetery		23d. LOCATION (City, town or county) (State) nr. New Windsor Md.	
24. FUNERAL DIRECTOR DR. H. H. Jones New Windsor Md.				25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07989

Item #3 ref. from birth cert. 77767 pc

CERTIFICATE OF DEATH

07973

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b Westminster d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Co. General Hospt.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead d. STREET ADDRESS Rt. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Deborah Lynn Middle Last Jo Ann E. Groomes		4. DATE OF DEATH June 18 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1967
9. AGE (In years last birthday) 5		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Groomes		14. MOTHER'S MAIDEN NAME Jo Ann E. Cremens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Groomes		Address Rt. 2 Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypoplasia 7545 Conditions, if any, which gave rise to immediate cause (b) Congenital (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pierre-Robin Syndrome		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE W. A. Young M.D. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town or county) (State) Woodlawn Balto. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tipton - Eline Funeral Home ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR JUN 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

07383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07990 CERTIFICATE OF DEATH 07974											
1. PLACE OF DEATH e. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Airy						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Airy					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. # 3						d. STREET ADDRESS R.F.D. # 3					
3. NAME OF DECEASED (Type or print) Harry E. Hahn						4. DATE OF DEATH Month June Day 28 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1909		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mt. Airy, Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hahn						14. MOTHER'S MAIDEN NAME Alverta Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No				16. SOCIAL SECURITY NO. 214-34-2815		17. INFORMANT Mrs Lynda Watkins Hahn, Item 2				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 5, 1965 , to June 28, 1967 , that (I) (we) last saw the deceased alive on June 28, 1967 , and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE W.B. Culwell						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/28/67	
22c. PHYSICIAN'S NAME (Type) W.B. Culwell						22d. ADDRESS 900 So. Main St Mt. Airy, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City, town or county) Mt. Airy, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth, Damascus, Md.						ADDRESS		25a. REC'D BY REGISTRAR JUL 3 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07991

CERTIFICATE OF DEATH

07975

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll County Westminister		c. LENGTH OF STAY IN lb DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital						d. STREET ADDRESS 3005 Milford Avenue					
3. NAME OF DECEASED (Type or print) Wheeler		First Knight		Middle Hancock		Last Hancock		4. DATE OF DEATH June 1 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1896		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fire fighter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pillar Point, New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank B. Hancock						14. MOTHER'S MAIDEN NAME Knight					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Myocardial infarction with DUE TO (c) Coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from April 1962 , to death , 19 67 , that (I) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 5 M, from causes and on the date stated above.											
22a. SIGNATURE <i>Joseph D'Antonio</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 3, 1967			
22c. PHYSICIAN'S NAME (Type) Joseph D'Antonio, M.D.						22d. ADDRESS 100 N. Broadway					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Ellsworth Armacost 4600 Liberty Hghts. Ave.						25a. REC'D BY REGISTRAR DATE JUN 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			

05801

CERTIFICATE OF DEATH

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

FOR STATE
HEALTH DEPT.

07992

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07976

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 21701		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Florann Hargett						4. DATE OF DEATH Month Day Year June 26 19 67							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-31		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Paul C. Welty, Sr.						14. MOTHER'S MAIDEN NAME Anna Scott							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-28-0630		17. INFORMANT Address Springfield State Hospital records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the nasal passages DUE TO and mouth by face being buried in a blanket. (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED 2 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE W. Glenn Speicher				EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 6/26/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-29-1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Frederick, Maryland			
24. FUNERAL DIRECTOR Hall's Funeral Home						ADDRESS Hall's Funeral Home		25a. REC'D BY REGISTRAR DATE JUN 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
07993					CERTIFICATE OF DEATH					07977					
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			c. LENGTH OF STAY IN 1b <u>1WK.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> 16-1										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSP.</u>					d. STREET ADDRESS <u>45 W. GREEN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>WILLIAM GILBERT HEAGY</u>					4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1967</u>										
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 1, 1908</u>		9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER SPORT GOODS STORE AND BARBER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>WILLIAM E. HEAGY</u>					14. MOTHER'S MAIDEN NAME <u>EMMA K. GARDNER</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>218-32-1082</u>		17. INFORMANT Address <u>NAME</u> <u>MRS. WM. G. HEAGY</u> Address <u> </u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Heart Disease</u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>										
20c. TIME OF INJURY. Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>June 8, 1967</u> , to <u>June 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 16, 1967</u> and that death occurred at <u>12:45 PM</u> , from causes and on the date stated above.															
22a. SIGNATURE <u>John S. Harsanyi</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u>					22b. DATE SIGNED <u>6/16/67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>6/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SANDY MOUNT CEM.</u>			23d. LOCATION (City or Town) (County) (State) <u>FINKSBURG RD MD.</u>							
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUN 20 1967</u>					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

07397

RECEIVED

07397

WILLIAM GILBERT HENRY
JUNE 15 1907
WHITE
CHINA TEA CO. AND RUBBER CARBON CO.
WILLIAM GILBERT HENRY
EMMA K. GARDNER
518-32-45-1000-1000-1000-1000

WILLIAM GILBERT HENRY
JUNE 15 1907
WHITE
CHINA TEA CO. AND RUBBER CARBON CO.
WILLIAM GILBERT HENRY
EMMA K. GARDNER
518-32-45-1000-1000-1000-1000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07978

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster R.D. 4</i>		c. LENGTH OF STAY IN <i>1b</i> <i>Westminster R.D. 4</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>HELENA JANE HORSEY</i>		4. DATE OF DEATH Month <i>6</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 4, 1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <i>72</i>
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>James H. Gray</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Mann</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>204-05-2248</i>	
17. INFORMANT <i>Mrs. Jean Spangler Finksburg, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221 Arteriosclerotic Changes</i> DUE TO (b) <i>Vascular Disease with</i> DUE TO (c) <i>decompensation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>William Spicker</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>6-24-67</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Park</i>
23d. LOCATION (City or Town) (County) (State) <i>Carroll Co. Md.</i>		24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>JUN 29 1967</i>		25b. REGISTRAR'S SIGNATURE <i>William Spicker</i>	

225

1920-1921

1894

07995

CERTIFICATE OF DEATH

07980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 13yr. 4days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30.4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3737 Keswick Road	
3. NAME OF DECEASED (Type or print) First Thelma Middle Victoria Last Irwin		4. DATE OF DEATH Month 6 Day 22 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/97
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earnest Evans		14. MOTHER'S MAIDEN NAME Raechael Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Coronary arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic depressive reaction, depressed type.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 6/18/1954 , to 6-22-1967 , that he (we) lost saw the deceased alive on 6-22-1967 , and that death occurred at 5 P.M. from causes and on the date stated above.			
22a. SIGNATURE Luis J. Antibas		22b. DATE SIGNED 6/22/67	
22c. PHYSICIAN'S NAME (Type) Luis J. Antibas, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, Burial (Specify)	23b. DATE THEREOF 26 June 1967	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City or Town) (County) (State) Wheeling Ohio Co., West Va.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 28 1967	

6252

1990

2

12/15/01

1. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

Corynebacterium jeikeium

2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07996						07981					
1. PLACE OF DEATH e. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marriottsville</u> d. STREET ADDRESS <u>Marriottsville Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Grace Edna Jaeger</u> First Middle Last 4. DATE OF DEATH <u>June 29, 1967</u> Month Day Year						5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 20, 1898</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Wm. P. Zepp</u> 14. MOTHER'S MAIDEN NAME <u>Lucille Arrington</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>-----</u> 17. INFORMANT <u>Mr. George A. Jaeger</u> Address <u>Marriottsville, Md</u>						18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Terminal pneumonia</u> <u>3 3 2 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Cerebral accident</u> DUE TO (c) <u>Cerebral Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>1 year</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 23, 1959</u> to <u>June 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1967</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Sani Okutman</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Obrecht Road, Sykesville, Maryland</u> 22b. DATE SIGNED <u>June 29, 1967</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LakeView Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>						25a. REC'D BY REGISTRAR <u>June 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

10000

UNITED STATES OF AMERICA

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

07997

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07982

1. PLACE OF DEATH a. COUNTY <i>Cavall</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN 1b <i>15 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Long View Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown, Md</i>	
e. STREET ADDRESS <i>103 First Ave</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mabel</i> Middle <i>Irene</i> Last <i>Koontz</i>		4. DATE OF DEATH Month <i>June</i> Day <i>5</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-19-89</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Philadelphia, Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel B. Beck</i>		14. MOTHER'S MAIDEN NAME <i>Hannah H. Fassbender</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-48-0454</i>	
17. INFORMANT <i>John Koontz</i>		Address <i>Reisterstown Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertensive arteriosclerotic</i> DUE TO (c) <i>cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>5/20</i> , 1967, to <i>6/5</i> , 1967, that (1) (we) last saw the deceased alive on <i>6/5</i> , 1967, and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W H Foard</i>		22b. DATE SIGNED <i>6/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. H Foard MD</i>		22d. ADDRESS <i>Manchester, Md 21102</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 8, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen mem Gardens</i>		23d. LOCATION (City, town or county) (State) <i>Finksburg, Maryland</i>	
24. FUNERAL DIRECTOR <i>H. J. Eckhardt Owings Mills, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 7 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

SECRET

72070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07998					07983				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		/Howard/ Carroll			a. STATE		b. COUNTY		
		MARYLAND			Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Sykesville					Baltimore		30.4		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Pullen Nursing Home					1249 Battery Ave.				
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print)					Month Day Year				
First Middle Last					6 28 1967				
5. SEX					6. DATE OF BIRTH				
Female					10 31 88				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					9. AGE (In years last birthday)				
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					78 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
Housewife					At Home				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Balto. Md.					U S A				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Walter					Minnie Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
No									
17. INFORMANT					Address				
Mrs. Thelma Zang					1249 Battery Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)					24 hours				
443X DUE TO					15 yrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					n				
DUE TO									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY					20d. INJURY OCCURRED				
Hour a.m. p.m.					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
19									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Feb 3 1967 to June 28 1967, that (I) (we) last saw the deceased alive on June 27 1967, and that death occurred at 2:15 PM, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Sani Okutman M.D.					6.28.67				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Sani Okutman					Sykesville, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF				
Burial					7 1 67				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
Cedar Hill					Brooklyn, A. A. CO. Md.				
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR				
Mc Cully					130 E. Fort Ave				
25b. REGISTRAR'S SIGNATURE					DATE				
J Charles Judge					JUN 30 1967				

CERTIFICATE OF DEATH

1900

1900

Blank certificate form with faint lines and text, including fields for name, age, sex, and date of death.

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07993

07984

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c. LENGTH OF STAY IN 1b 4mo. 16days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1228 Tanley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Mary Last Lamb				4. DATE OF DEATH Month 6 Day 6 Year 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/82		9. AGE (In years lost birthday) yrs. 84	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Guiser				14. MOTHER'S MAIDEN NAME Elizabeth Barry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 175-01-1324		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Rheumatic heart disease DUE TO (c) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH days years days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Chronic brain syndrome associated with cerebral arteriosclerosis without qualifying phrase.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 1/20/ , 19 67 , to 6/6/ , 19 67 , that he (we) last saw the deceased alive on 6/6/ , 19 67 , and that death occurred at 10:45 p.m. , from causes and on the date stated above.							
22a. SIGNATURE <i>Naci N. Buyukunsal</i> M.D.				22b. DATE SIGNED 6/6/67			
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-10-67		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Charleroi PA.	
24. FUNERAL DIRECTOR <i>Harry Weir Knight</i>				25a. REC'D BY REGISTRAR DATE JUN 12 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1953

ESTIMATE OF DEATH

1953

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Income		Assets		Liabilities		Net Worth		Other	
John Doe		45		Male		White		Catholic		Married		Teacher		High School		\$10,000		\$5,000		\$5,000		\$15,000		None	
Jane Doe		42		Female		White		Catholic		Married		Homemaker		High School		\$8,000		\$3,000		\$5,000		\$13,000		None	
Robert Doe		15		Male		White		Catholic		Single		Student		High School		\$2,000		\$1,000		\$1,000		\$3,000		None	
Mary Doe		12		Female		White		Catholic		Single		Student		High School		\$1,500		\$800		\$700		\$2,200		None	
Total		104		5 Males		5 Females		5 Catholics		3 Married		2 Single		4 High School		\$21,500		\$9,800		\$11,700		\$33,200		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08000

07985

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>914 KENT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maud</u> Middle <u>Lawrence</u> Last <u>Lawrence</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25, 1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS. Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Ottawa Canada</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Hall</u>		14. MOTHER'S MAIDEN NAME <u>Helen A. Lawrence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Helen A. Lawrence</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Chronic heart failure</u> DUE TO (c) <u>Arteriosclerosis, generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>2 yrs</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-17-67</u> to <u>6-18-67</u> , that (I) (we) last saw the deceased alive on <u>6-17-67</u> , and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Sani Okutman</u> M.D.		22b. DATE SIGNED <u>6-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Heemon Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Heemon New York</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>1378 Suburban</u>		DATE <u>JUN 21 1967</u>	

00000

00000

CERTIFICATE OF DEATH

[Faint, mostly illegible text, likely a form or document, possibly a death certificate. Some words like "Name", "Age", "Sex", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", "Witness", "Registrar" are faintly visible.]

JUN 21 1907

07986

08001

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD.</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD #5 WESTMINSTER, MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSP.</u>				d. STREET ADDRESS <u>UNIONTOWN RD. BOX #106</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALVA</u> Middle <u>THEODORE</u> Last <u>LONG</u>				4. DATE OF DEATH Month <u>6</u> - Day <u>23</u> - Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 29 1905</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>23</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE FACTORY FOREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRED COUNTY U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES MESLEY LONG</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA T. LONG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 05-5408 MFE.</u>		17. INFORMANT <u>MRS. VIOLA C. LONG</u> Address <u>RD #5 BOX 106 WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC OBSTRUCTIVE</u> 5272 DUE TO (b) <u>PULMONARY DISEASE</u> DUE TO (c) <u>YEARS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>67</u> , to <u>6/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/23</u> , 19 <u>67</u> , and that death occurred at <u>1:42</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Vincent J. Fiocco</u>				22b. DATE SIGNED <u>6/23/67</u>		22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO, MD.</u>	
22d. ADDRESS <u>BANCHOR ST. WESTMINSTER, MD.</u>							
23a. BURIAL-CREATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEMORIAL</u>		23d. LOCATION (City or Town) (County) (State) <u>FINKSBURG CARROLL MD.</u>	
24. FUNERAL DIRECTOR <u>James G. Saffell</u>				25a. REC'D BY REGISTRAR <u>JUN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

00000

CARROLL COUNTY
 WESTMINSTER MD 17356
 CARROLL COUNTY GEN HOSP. UNIONTOWN RD. 20710
 ALVA THEODORE LONG
 M W
 JAN 28 1905
 SHOE MAKER KENNY HANSHAW FRED
 JAMES IRLEY LONG
 VIRGINIA T. LONG
 213 05-080 ME. RD 2 DOWNE WESTMINSTER MD
 MS VIRG C LONG

VINCENT J. FIOCCO MD RANCHER ST WESTMINSTER MD
 BURIAL 1/20/17 EVERGREEN MEMORIAL PARKWAY
 1/20/17

08002

CERTIFICATE OF DEATH

07987

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN lb <u>11 mo. 24 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1721 Lafayette Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dewey</u> Middle <u>NMN</u> Last <u>Madison</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-10</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Madison</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Unkn.</u>		17. INFORMANT <u>Springfield State Hospital records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism (source unknown)</u> DUE TO (b) <u>Right heart failure</u> DUE TO (c) <u>Hypertrophy of right and left ventricle muscles</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome of unknown cause with behavioral reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> , 19 <u>66</u> , to <u>6-27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6-27-67</u> 19 <u>67</u> , and that death occurred at <u>9:50 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Heinz Klaatsch</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Heinz Klaatsch, M.D.</u>				22d. ADDRESS <u>Springfield State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sykesville, Maryland A A County Md</u>	
24. FUNERAL DIRECTOR <u>Halstead Funeral Home</u>				ADDRESS <u>918 North Ave</u>		25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2002

— 200 —

• *Ref:*

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07988

08003

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>26 S. Church Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>26 S. Church Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROY MILTON MANN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1967</u>		5. SEX <u>male</u>			
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1905</u>			
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mill work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Congoleum Nairn</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>J. William Mann</u>			
14. MOTHER'S MAIDEN NAME <u>Mina May Buckingham</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes give war or dates of service) <u>--</u>			
16. SOCIAL SECURITY NO. <u>216-07-4202R</u>				17. INFORMANT <u>Howard Mann</u> Address <u>15 Willow Avenue Westminster, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION</u> (b) <u>CORONARY ATHEROSCLEROSIS</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 12, 1967</u> to <u>JUNE 25, 1967</u> that (I) (we) last saw the deceased alive on <u>JUNE 12, 1967</u> and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William L. Stewart, M.D.</u>				22b. DATE SIGNED <u>6/25/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. WILLIAM L. STEWART</u>				22d. ADDRESS <u>19 RIDGE RD. WESTMINSTER, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>June 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery Finksburg, RD Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Meyer, Jr., Westminster, Md.</u> ADDRESS <u> </u>							
25a. REC'D BY REGISTRAR <u>JUN 28 1967</u>				25b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08003

CHRYSLER CREDIT CORP.

10/15/1961

08004

CERTIFICATE OF DEATH

07989

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville		c. LENGTH OF STAY IN lb 1 d. 23hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 170 Williams Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Henry Maus				4. DATE OF DEATH Month 6/22/67 Day 19 Year 19			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/19		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY GAS & Electric		11. BIRTHPLACE (County & State, or foreign country) Carroll Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Maus				14. MOTHER'S MAIDEN NAME HARRIET Babylon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-45		16. SOCIAL SECURITY NO. 217-05-9604		17. INFORMANT Address Springfield Hospital Records, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 307X IMMEDIATE CAUSE (a) Delirium Tremers DUE TO (b) Alcohol Intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20 1967 , to June 22, 1967 , that (I) (we) last saw the deceased alive on June 22 1967 , and that death occurred on 12:35 AM from causes and on the date stated above.							
22a. SIGNATURE <i>San Subias</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/22/67	
22c. PHYSICIAN'S NAME (Type) San Subias				22d. ADDRESS Springfield Hospital, Sykesville Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-67		23c. NAME OF CEMETERY OR CREMATORY Kniders Cemetery		23d. LOCATION (City or Town) (County) (State) Westminster Carroll Md	
24. FUNERAL DIRECTOR John E. Myers Jr.				ADDRESS Westminster, Md		25a. REC'D BY REGISTRAR DATE JUN 26 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

UNITED STATES OF AMERICA

100-100000

Control

Medical

Control

Department of State Hospital

170 Madison Avenue
New York 17, N.Y.

Charles Henry
Henry Henry
Mary Mary

last name

first name

1-1-1

Alcohol Intoxication

Delirium Tremens

100-100000

June 22, 1954
June 22, 1954

100-100000

Control

Control

Control

Control

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08005
CERTIFICATE OF DEATH

07990

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middleburg				c. LENGTH OF STAY IN 1b 6 Weeks					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookfield Manor Nursing Home				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Taneytown					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS Mailing Address Md. Littlestown, Pa. R.D.1, Carroll Co.					
3. NAME OF DECEASED (Type or print) First Elmer Middle J. H. Last Mayers				4. DATE OF DEATH Month June Day 13 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1888			
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Samuel Mayers				14. MOTHER'S MAIDEN NAME Maggie Harner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 194-36-2244		17. INFORMANT Address Carroll Co., Md. Beulah M. Mayers, Littlestown, Pa. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia								INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/1/67 , 19... to 6/13/67 , 19..., that (I) (we) last saw the deceased alive on 6/13/67 , 19..., and that death occurred at 11 A.M. , from the causes and on the date stated above.									
22a. SIGNATURE J. A. Carico M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/13/67			
22c. PHYSICIAN'S NAME (Type) Richard A. Little				22d. ADDRESS Union Bridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Gardens		23d. LOCATION (City, town or county) (State) R.D.3, Gettysburg, Adams Co. Pa.			
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		25a. RECEIVED BY REGISTRAR JUN 15 1967 DATE			
				25b. REGISTRAR'S SIGNATURE Charles Judge					

00000

00000

Garrett

Harland

Garrett

Mississippi

2 Weeks

Nov. 12, 1888

Geological Survey, Washington

Littleton, Pa. N.W., Garrett

To 13 07

Nov. 12, 1888

White

Male

Garrett County, Md.

Land

Garrett

Garrett County, Md.

Garrett County, Md.

Garrett County, Md.

184-30-2246 - William M. Garrett, Littleton, Pa. 1

Garrett County, Md.

Garrett County, Md.

Garrett

Garrett

Garrett County, Md.

Garrett County, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08006 07991											
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>4 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RURAL - Sykesville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Golden Age Guest Home</i>						d. STREET ADDRESS <i>R.D. 2</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary B Morrison</i> First Middle Last						4. DATE OF DEATH <i>June 21st</i> 19 <i>67</i> Month Day Year					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/13/1886</i>		9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Fayette Co., Penna</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Calvin Bryner</i>						14. MOTHER'S MAIDEN NAME <i>Eliza Ann</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Guy W. Morrison</i>			Address <i>Same As #2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Carcinoma</i> 1539 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Respiratory</i> DUE TO (c) <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i> <i>03</i> <i>3</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>June 4</i> , 19 <i>67</i> , to <i>June 21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>June 20</i> , 19 <i>67</i> , and that death occurred at <i>4:22 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>H. H. Martin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>June 21-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>H. H. MARTIN</i>						22d. ADDRESS <i>Westminster Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/24/1967</i>		23c. NAME OF CEMETERY <i>Lakeview Mem. Gardens</i>				23d. LOCATION (City, town or county) (State) <i>Carroll Co., Md.</i>			
24. FUNERAL DIRECTOR <i>C. M. Waltz</i>						ADDRESS <i>Box 241 Sykesville, Md.</i>			25a. REC'D BY REGISTRAR <i>JUN 26 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		

1000

80

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08007 CERTIFICATE OF DEATH 07992

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION MILLS c. LENGTH OF STAY IN 1b 2 YRS, 6 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEADOW VIEW CONSV. HOME		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER, RD #7 067 d. STREET ADDRESS PLEASANT VALLEY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADA VIOLA MYERS		4. DATE OF DEATH Month Day Year JUNE 4 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12, 1888 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE COOK IN INSTITUTION		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME TOBIAS MARTIN		14. MOTHER'S MAIDEN NAME IDA OHLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 220-24-8562	17. INFORMANT MARTIN F. MYERS, WESTMINSTER, RD 7 MD. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 260x Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DIABETES MELLITUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 7 YEARS 7 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL , 19 66 , to JUNE , 19 67 , that (I) (we) last saw the deceased alive on JUNE 4 , 19 67 , and that death occurred at 1235 M, from the causes and on the date stated above.			
22a. SIGNATURE Daniel I Welliver 22c. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER		22b. DATE SIGNED 6-4-67 22d. ADDRESS 19 RIDGE ROAD WESTMINSTER MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/7/67	23c. NAME OF CEMETERY OR CREMATORY PLEASANT VALLEY CEM.	23d. LOCATION (City, town or county) (State) WESTMINSTER, RD #7 MD.
24. FUNERAL DIRECTOR J.E. Myers Jr., Westminster, Md 21157		25a. REC'D BY REGISTRAR JUN 7 1967 25b. REGISTRAR'S SIGNATURE J Charles Judge	

28003

OFFICE OF DEATH

03/00/00

THE STATE OF TEXAS
COUNTY OF DALLAS
I, JAMES H. MARTIN, County Clerk of said County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

DIRECTOR, WELLINGTON
ARTERIO-SCLEROTIC CHRONIC CURVATURE
DIPLOMA

DANIEL I. WELLIVER, M.D.
JAMES H. MARTIN, County Clerk
APRIL 10, 1900
JAMES H. MARTIN, County Clerk
JAMES H. MARTIN, County Clerk

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00

3

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08008
07993
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY in 1b <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> <u>06-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long Meadow Drive</u>				d. STREET ADDRESS <u>Long Meadow Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth E. Myers</u>		First Middle Last		4. DATE OF DEATH <u>June 24, 1967</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1901</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Wm R. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Shipley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Harry Myers - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease,</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary thrombosis, acute;</u> DUE TO (c) <u>Cardiac Arrest.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>June 1966</u> <u>through</u> <u>June 24, 67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>June 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> , 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 27, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>JUN 29 1967</u>		25b. REGISTRAR'S SIGNATURE	

50080

1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08003 CERTIFICATE OF DEATH 07994

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gist</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>90 Ross Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster</u> d. STREET ADDRESS <u>R. D. 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sophonuia</u> Middle <u>E.</u> Last <u>Pickett</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer H ood</u>		14. MOTHER'S MAIDEN NAME <u>Cora Ways</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ruby Logue R.D.2 Mt. Airy, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease,</u> <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac failure; Arteriosclerosis, generalized;</u> DUE TO (c) <u>Gastro-intestinal bleeding, cause unknown.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6/19/67</u> <u>through</u> <u>6/25/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 19 67</u> , to <u>June 25, 19 67</u> , that (I) (we) last saw the deceased alive on <u>June 25, 19 67</u> , and that death occurred at <u>10:45</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>June 26, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/28/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Taylorville</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUN 28 1967</u>	

00000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

08010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07995

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister c. LENGTH OF STAY IN 1b HOURS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister d. STREET ADDRESS R.D. #5 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DONALD L. ROBBINS, Jr.		4. DATE OF DEATH Month 6 Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15 1967
9. AGE (In years lost birthday) yrs. 3 1/2		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GETTYSBURG, PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD LEE ROBBINS		14. MOTHER'S MAIDEN NAME EDNA MAY PETREY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT FATHER DONALD ROBBINS WESTMINSTER		Address RD #5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 525X IMMEDIATE CAUSE (a) Interstitial pneumonitis - (SDII) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		22. DATE SIGNED 6-11-67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6/13/67	
23c. NAME OF CEMETERY OR CREMATORY TRINITY LUTHERAN		23d. LOCATION (City or Town) (County) (State) TAKEV TOWN CARROLL MD	
24. FUNERAL DIRECTOR James G. Saffell - WESTMINSTER, MD		25. REC'D BY REGISTRAR JUN 14 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

1963

01087

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07996

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b Finksburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospt.		d. STREET ADDRESS R.T. 1	
3. NAME OF DECEASED (Type or print) RICHARD R. Rupp		4. DATE OF DEATH Month 6 Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1897
9. AGE (In years lost birthday) 70 yrs.		10. IF UNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Rupp		14. MOTHER'S MAIEN NAME Laura V. Belt	
15. WAS OCEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-8824A	
17. INFORMANT Emma Blanch Rupp R.t. 1 Finksburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO this disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Several yrs	
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/67	
23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.		25a. REC'D BY REGISTRAR JUN 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
2DM 1/65

08012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07997

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RT # Manchester 06-1</u>		d. STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Scharrer</u> Last <u>Scharrer</u>		4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mike Scharrer</u>		14. MOTHER'S MAIDEN NAME <u>Thersa Galbeck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-24-2130</u>	
17. INFORMANT <u>Mrs. Margaret Scharrer (Wife)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left lung</u> DUE TO <u>metastasis to brain</u> (b) <u></u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>1 month</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>65</u> , to <u>6/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Foard</u>		22b. DATE SIGNED <u>6/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard MD</u>		22d. ADDRESS <u>Manchester, Md 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/4/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Manchester Carroll Co. Md</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 5 1967</u>	

RECEIVED
DEPARTMENT OF HEALTH
OFFICE OF THE SECRETARY
WASHINGTON, D. C.

1934

TO THE SECRETARY
FROM THE
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08013

07998

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Md</u> c. LENGTH OF STAY IN 1b <u>2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home, 128 N. Main, Monks, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monks, Md</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>M.</u> Last <u>Seabreeze</u>		4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Laura Montgomery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-6042A</u>		17. INFORMANT (husband) <u>Carroll L. Seabreeze</u> Address <u>Monks Rd, Monks, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO (b) <u>Arterio-sclerotic C.V. Disease</u> DUE TO (c) <u>marked Cerebral Softening</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1965</u> to <u>June 11, 1967</u> , that (II) (we) last saw the deceased alive on <u>June 10, 1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Maurice C. Carter</u>				22b. DATE SIGNED <u>6-11-67</u>			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>					
25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>				25b. REGISTRAR'S SIGNATURE			
DATE <u>JUN 12 1967</u>				25c. REGISTRAR'S SIGNATURE			

21032

Leonard J. Beck, Inc., 2302 Hartford St.,

၆၃၂၇

72-11-2

Expenditure

1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 25

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08014

CERTIFICATE OF DEATH

07999

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R.D. 4 Westminster</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R.D. 4 Westminster</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		d. STREET ADDRESS <u>161</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Margaretta</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1890</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hesson</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-9158</u>	
17. INFORMANT <u>MRS MERLE PERKINS, FINKSBURG, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & its compensations</u> (c) <u>Cerebral Vascular Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several</u> <u>yes</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>yes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 24, 1967</u> to <u>June 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 27, 1967</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William Speisher</u> M.D.		22b. DATE SIGNED <u>6-24-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kriders Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Westminster, MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Myers Jr. Westminster, Md.</u>		25. REC'D BY REGISTRAR <u>JUN 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-10-10

10-10-10

M

1

10-10-10

10-10-10

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08015

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08000

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb. <u>37 yrs. 6 mo. 21 da.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) <u>Harry Sobus</u>		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unkn.</u>
9. AGE (In years lost birthday) yrs. <u>60?</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paperhanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paperhanging</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Springfield State Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary arteriosclerosis and</u> DUE TO (c) <u>coronary artery thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, hebephrenic type</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. L. Spencer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. L. Spencer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>6-30-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 5th, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR <u>Frederick D. Miller Inc.</u>		25a. REC'D BY REGISTRAR <u>JUL 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

41089

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b Unknown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jones Motors Parking Area - Mt. Airy		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Unknown // Md. b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown // Adelphia d. STREET ADDRESS Unknown // 9907 Laconia Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Easterly Last Sproles		4. DATE OF DEATH Month June Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 28, 1923
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
11. BIRTHPLACE (State or foreign country) Shores, Virginia		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Dr. John Sproles		14. MOTHER'S MAIDEN NAME Grace Pupugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 224-24-8503	
17. INFORMANT Mrs Grace East		Address 9707 Laconia Drive, Adelphi	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty alteration of liver DUE TO (b) 916.5 DUE TO (c) Carbon monoxide inhalation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carbon monoxide inhalation			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Terminal burning due to conflagration in automobile	
20c. TIME OF INJURY Month, Day, Year Unk Hour a.m. Unk 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Mt. Airy Carroll Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 6/6/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Stemp Cemetery	23d. LOCATION (City or Town) (County) (State) Sugar Grove, Smyth Co., Vir
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.		25a. REC'D BY REGISTRAR JUN 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

000015

08016

Jan 28, 1952

Shores, Virginia

Irma Ingram

Dr. John S. Jones

Employed

221-21-1001

NY 11

Yes

Warrant

June 1, 1952

1111 & 1112 Ave. 1900-07 Eastern Ave.

Super Groves, Super Co.

June 1, 1952

08017

CERTIFICATE OF DEATH

08002

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN lb 35y. 10m. 26d.		d. STREET ADDRESS unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katharyn E. Steet		4. DATE OF DEATH Month 6 Day 6 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/08/01
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Steet	
14. MOTHER'S MAIDEN NAME Hilda Swift		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 216-03-3106T		17. INFORMANT Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible diabetic acidosis DUE TO (b) Dehydration DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, chronic undifferentiated type.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 7/10/1931 to 6/6/1967 , that he (we) last saw the deceased alive on 6/6/1967 and that death occurred on 6:35^a M. from causes and on the date stated above			
22a. SIGNATURE <i>Naci N. Buyukunsal</i>		22b. DATE SIGNED 6/6/67	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-7-67	23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery	23d. LOCATION (City or Town) (County) (State) Sykesville Md.
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Sykesville Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JUN 12 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03017

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

10/30/01

08018

CERTIFICATE OF DEATH

08003

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 21 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 530 Beall Avenue	
3. NAME OF DECEASED (Type or print) First LEO Middle LEONARD Last SWANN		4. DATE OF DEATH Month 6 - Day 7 - Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-02
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper/Gardener		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Swann		14. MOTHER'S MAIDEN NAME Fannie (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO (b) Cirrhosis of the liver DUE TO (c) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH Days Years Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with alcohol intoxication without qualifying phrase.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 5-16-67 , 19__ to 6-7-67 , 19__, that he (we) last saw the deceased alive on 6-7-67 , 19__, and that death occurred at 6:45P M, from causes on and on the date stated above.			
22a. SIGNATURE Agustin del Campo.		22b. DATE SIGNED 6-8-67	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/67	
23c. NAME OF CEMETERY OR CREMATORY Rockville		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR DATE JUN 12 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A1022

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08005

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>			c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Corner Route 94 + Mary Ave</u>				d. STREET ADDRESS <u>179 Franklin Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Larry</u> Last <u>Webster</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 3, 1958</u>	
9. AGE (In years last birthday) <u>8</u> yrs.				IF UNDER 1 YEAR Months <u>8</u> Days <u>29</u> Hours <u>19</u> Min. <u>67</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>3rd grade</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Lawrence W. Webster</u>				14. MOTHER'S MAIDEN NAME <u>Harrnett H. Long</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lawrence W. Webster</u> Address <u>179 Franklin Ave, Westminster, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured neck + multiple injuries</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>walked ground in front of building</u>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>6/29 1967</u> p.m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 94 + Mary Ave</u>	
20f. (City or town) <u>Westminster</u>				20g. (County) <u>Carroll</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William Speicher</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William Speicher</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u>	
24. FUNERAL DIRECTOR <u>J. Z. Myer, Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
23d. LOCATION (City or Town) <u>Rural Westminster, Md.</u>				23e. (County) <u>Carroll</u>		23f. (State) <u>Md.</u>	
22. DATE SIGNED <u>6/29/67</u>							

01030

[Faint, illegible handwriting on lined paper]

[Faint, illegible handwriting at the bottom of the page]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08020

08008

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Church St.</u>				d. STREET ADDRESS <u>Church St.</u>			
3. NAME OF DECEASED (Type or print) <u>Millard</u> First <u>H.</u> Middle <u>Week</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-1885</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>			
13. FATHER'S NAME <u>James R. Weer</u>				14. MOTHER'S MAIDEN NAME <u>Ruth M. Tucker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mr. James Weer - Balto., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> 10492 DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10492</u> <u>10492</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enderteritis obliterans involving both hands - both feet</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>7/June, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/June 1967</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>7/June/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm H. LAWSON, Jr</u>				22d. ADDRESS <u>Box 54 RD #2 Sykesville Maryland - 21784</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Cremation</u>		<u>6-11-67</u>		<u>Lee's Crematory</u>		<u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
DATE <u>JUN 12 1967</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Figure 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08021 CERTIFICATE OF DEATH 08027									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>			c. LENGTH OF STAY IN 1b <u>47</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead, Md 061</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>223 N Main St</u>					d. STREET ADDRESS <u>223 N. Main St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>Alvorta</u> Last <u>Wentz</u>					4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23/94</u>		9. AGE (in years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Nicholas Rinnamor</u>					14. MOTHER'S MAIDEN NAME <u>Charlotte Wilhelm</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-9944</u>		17. INFORMANT <u>John N Wentz</u>			Address <u>Hampstead, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>5 yrs</u>									INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1953, to <u>June 29</u> , 1967, that (I) (we) last saw the deceased alive on <u>5/18</u> , 1967, and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Foard</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/29/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard - M.D.</u>					22d. ADDRESS <u>Manchester, Md 21102</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hampstead Carroll Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

13080

703-24-1144